

**Observations, Assessment, and Recommendations
for PMTCT Programs at
St. Mary's Hospital, St. Martin's Hospital
and Onandjokwe Hospital
in Namibia**

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Site Visits: August 23, 2003-September 5, 2003

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Background:

While Namibia has made impressive gains in economic, political and social development since its independence 13 years ago, its most precious asset, its human resource base is being devastated by the HIV/AIDS epidemic. According to the 2002 HIV sentinel sero-survey, HIV prevalence varies by region from 9 percent to 43 percent, with an overall estimated 22 percent crude prevalence rate for sexually active adults. Resultantly, Namibia is one of the top five AIDS-affected countries in the world. Heterosexual sex and mother to child transmissions are the main routes of transmission for HIV in Namibia. Of the 75, 000 births that occur annually, approximately 17,500 (23%) are to HIV positive women. Based on a transmission rate of 30% to 40%, it is anticipated that approximately 5,250 to 7,000 newborns will become infected with HIV each year. According to the DHS, of the most recent births more than 90% of pregnant women receive antenatal care from a doctor or nurse. More than 75% of women who gave birth in the past five years were assisted by trained medical personnel. Ninety four percent (94%) of women breastfeed their infants during the first three months of life; 92% of children continue breastfeeding at 4 to 6 months of life; and 75% of children continue to breastfeed at 10-12 months of life. Twenty six percent (26%) of children are exclusively breastfed from zero to three months of life; with three percent (3%) still exclusively breastfeeding at four to six months of age.

Namibia recognizes that HIV/AIDS is creating enormous new challenges for the future development of the country. A 2002 Ministry of Health and Social Services (MoHSS) report projected that, by 2003, Namibia would have 114,500 orphans (including vulnerable children to age 18), of which 2/3 are attributable to the HIV/AIDS epidemic. Moreover HIV/AIDS is exacerbating shortages of skilled workers in certain sectors, e.g. teachers and nurses, reducing productivity, and impeding economic growth.

After consulting widely with the Namibian public, private, and non-governmental leaders and organizations, USAID Namibia fashioned its strategic objective programming as a part of its HIV/AIDS strategy. The Mission's Strategic Objective is to "Reduce the spread and impact of HIV/AIDS in Namibia". It plans to achieve this objective by utilizing a number of interventions. Which include:

- IR.1. Sexual behavior changes reducing risk of HIV transmission
- IR.2. Mother to Child transmission prevented
- IR.3. PLWHA and families receiving quality care, support and treatment, including HAART
- IR.4. OVC provided quality care and support services.

These strategic objectives complement the GRN objectives as set out in the National Strategic Plan on HIV/AIDS, the Medium Term Plan II (MTP II 1999-2004) and the National Development Plan II (NDPII)

Some of the activities for the programming include the requests made by the MoHSS for support in the roll-out of voluntary counseling and testing programs in MoHSS supported faith based facilities and communities; social marketing throughout Namibia in public and private sectors, and support the roll-out of PMTCT-plus programs in MoHSS supported faith based health facilities which include at

least five mission hospitals and approximately 30 associated health facilities. Goals of USAID/Namibia as stated in their Initial Plan Proposal for the President's Initiative include:

1. Launch and establish a national PMTCT program
2. Maximize PMTCT program coverage of HIV-positive deliveries with at least nevirapine as quickly as possible which may include the provision of nevirapine to women of unknown HIV status
3. Strengthen MoHSS coordination and support to PMTCT implementation at the national, regional, district, and health facility levels;
4. Provide prevention programs as well as access to VCT, PMTCT, treatment, maternal and child transmission

Purpose of the Visit:

The purpose of the visit to Namibia was to provide technical assistance to the USAID/Namibia Mission by conducting field assessments of PMTCT programs at three faith based hospitals; evaluate the ability to integrate family planning referral, counseling, and service delivery into PMTCT programs, and to evaluate postabortion care activities in one clinical site.

Methodology:

The field visits occurred between August 23, 2003 and September 5, 2003. Information was gathered via field visits to three faith-based hospitals, interviews with hospital administrative staff, medical and nursing staff, VCT counselors, women receiving prenatal care, representatives of Lifeline/Childline, Catholic Health Services, and Katatura hospital. Observations were made of staff during service delivery and counseling sessions with patients. Documents were also reviewed to garner further information.

Findings:

Findings will be reported according to each institution/organization. Impressions/challenges with recommendations for action/interventions will be included in the assessment of each institution. Lastly, interviews held with representatives from Katatura Hospital and Lifeline/Childline will be noted following information on the site visits.

Policy Environment for combating HIV/AIDS in Namibia

There is very strong support from the Ministry of Health and Social Services in Namibia for combating the HIV/AIDS epidemic. This is evidenced in the existence of the following documents:

1. Republic of Namibia Ministry of Health and Social Services Guidelines for the Clinical Management of HIV and AIDS
2. Republic of Namibia Ministry of Health and Social Services Guidelines for Counseling of HIV/AIDS and Sexually Transmitted Diseases, June 2001
3. Republic of Namibia Ministry of Health and Social Services Guidelines for Anti-Retroviral Therapy, First Edition, April, 2003
4. Republic of Namibia Ministry of Health and Social Services Policy on HIV/AIDS: Confidentiality, Notification, Reporting and Surveillance

5. Iatesta, M. and McKelroy, V.S. Report to Ministry of Health and Social Services External Review Team Voluntary Counseling and Testing Mid-Term Review Namibia Medium Term Plan II on HIV/AIDS (1999-2004), January 16-24, 2003.

These documents serve as the undergirding policy for the national medical and social services response to HIV/AIDS in Namibia. Most of the documents are user friendly, some available in additional languages. The clinical management guidelines are pocket sized making it easy for the health care practitioner to carry with them for easy reference.

Site Visits

Site visits were done at St. Mary's Hospital in Rehoboth, St. Martin's Hospital in Oshikuku, and Onandjokwe Hospital in Onandjokwe. Interviews were held and tours were done to assess staffing, the facilities, and availability of supplies for conducting successful PMTCT programs.

St. Mary's Hospital – Rehoboth Health District

Informants:

Sr. Raphaela Handel – Executive Director – Catholic Health Services

E. Izales, RN – Charge Nurse – Maternity Ward

E. Gaweses, RN – Charge Nurse – Theatre

Irene Mouton – PMTCT Coordinator

Dr. D. M. Kangudie – Physician, St. Mary's Hospital

K. Husselmann

St. Mary's Hospital is a 150 bed facility which has served as the District Hospital for Rehoboth since 1943. It is owned by the Catholic Church and is managed by Catholic Health Services. Besides St. Mary's Hospital, there is the Rehoboth Health Centre serves as the outpatient department and is managed by the Ministry of Health. There are 3 rural clinics and 18 outreach point that exist on farms for which there are monthly visits. There are 4 doctors working in these settings (two government employees and two employed by Catholic Health Services). The Superintendent of St. Mary's Hospital also serves as the Principal Medical Officer of the health district.¹

The total population of the Rehoboth District is 29, 840 people. The rate of HIV prevalence is between 10% and 43%; with 10% of adults aged 15 to 49 being HIV positive. In 2002, 1414 HIV tests were conducted at St. Mary's Hospital with 323 (22.8%) of those tests being positive. Forty five (45) additional patients were diagnosed with clinical AIDS.²

VCT and HIV Services at St. Mary's Hospital

Services offered by St. Mary's Hospital include VCT and HIV testing for sick patients with clinical signs of HIV/AIDS; HIV testing since 1999 for all TB patients; VCT for antenatal care attendants; treatment of opportunistic infections; intensive health education according to the ABC slogan of the Catholic Aids Action (CAA), participation in the Diflucan Partnership Program (DPP)

¹ Kangudie, D.M. Presentation of Rehoboth District and the Situation of HIV/AIDS. Rehoboth, 28 August 2003.

² Mouton, I. PMTCT: Past and Future with Bush Initiative

and PMTCT which was implemented in September, 2002 as a specific initiative of Catholic Health Services.³

The PMTCT Program at St. Mary's Hospital

At St. Mary's Hospital, there are approximately 50 to 60 births per month with ± 5 births/month (10%) being to HIV positive mothers. In September, 2002, the PMTCT program was initiated as a hospital based program. It has one designated staff person who serves as the PMTCT Program Coordinator. Antenatal services include antenatal care, group education whose topics include HIV/AIDS, vitamin and iron supplementation as needed, follow-up antenatal visits, delivery, and a six week postpartum visit. Pre-test counseling and testing for HIV/AIDS is made available for all pregnant women with official enrollment into the PMTCT program when the mother has a positive HIV test result.

Activities of the PMTCT program include pre and post-test counseling for HIV; nevirapine treatment for HIV positive mothers and their infants; counseling on feeding; weekly home visit follow-up for 6 weeks post delivery; infant treatment of co-trimoxazole at six weeks of age, and initiation of immunizations at six weeks of age. At 34 weeks gestation, the mother is provided with two Nevirapine tablets and is instructed to take the initial tablet at the onset of labor. It is recommended that if mothers choose to exclusively breastfeed, that they do so for 4 months in keeping with WHO guidelines for breastfeeding. After delivery, the infant receives Nevirapine syrup in the labor ward within 72 hours after birth. Upon discharge from the hospital, the PMTCT coordinator conducts weekly home visits on the mother and infant for six weeks.⁴

From September, 2002 through July, 2003, there were 612 women who sought antenatal care services; 612 (100%) had HIV testing done. Sixty (9.8%) of the women had positive test results; 562 (90.2%) were found to be HIV negative. Forty seven (78%) of the HIV positive women were enrolled into the PMTCT program. Of this number 37 (79%) delivered at St. Mary's Hospital; 31 (65%) received nevirapine and 37 (79%) women received follow-up for 6 weeks in the PMTCT program. Forty three babies received nevirapine treatment after delivery. This number accounts for the birth of twins and infants of mothers who had not received antenatal care at St. Mary's Hospital.⁵ Family planning counseling was not automatically inclusive in the six week postnatal visit.

Family Planning and Sexually Transmitted Diseases (STDs)

While Natural Family Planning (NFP) is the officially recognized method by the Catholic Church, their family planning clinics also offer injectables, oral contraceptives, and bilateral tubal ligation. No IUDs are utilized as they are seen as abortifacients. Abortion remains illegal in Namibia. STD evaluation and treatment for women is handled on a syndromic basis. There are no individual STD clinics within the CHS system.

Physical Setting:

A tour of the facility found the labor and delivery ward to be clean and offering privacy and confidentiality to the patients. Generally the rooms were semi private with two beds to a room for women during labor and the postnatal period. There was no overcrowding with no more than two

³ Kangudie, D.M. Presentation of Rehoboth District and the Situation of HIV/AIDS. Rehoboth, 28 August 2003.

⁴ Husselmann, K. ANC PMTCT Rehoboth Health Centre. Presentation of Project Overview.

⁵ Mouton, I. PMTCT: Past and Future with Bush Initiative

women to a room on the postnatal room. All mattresses were off the floor onto bed frames. Equipment was available including ultrasound machine, equipment for infant resuscitation. There was a generous stocking of sterile and non-sterile gloves, sterile needles and syringes. A plastic bin was used for disposal of needles. The theatre was found to be clean. Disposable drapes had been donated to the hospital last year. As per the head nurse for the theatre, these drapes were used for cesarean sections done on the HIV positive mothers. Guidelines on precautions for preventing HIV transmission during labor and delivery were posted on the wall in the delivery rooms. PMTCT national guidelines were only present in the PMTCT Coordinator's office. Guidelines for ARVs were also present. Infection Control Committees are on the maternity wards to address national guidelines. Guidelines regarding Universal Precautions were not seen at the nurse's station, in labor and delivery, in the delivery room or in the PMTCT Coordinator's office. No patient education materials were seen. The forms utilized for mothers enrolled in the PMTCT program did not indicate family planning counseling and referral as activities to be completed. The duration of the activities being monitored ended at six week post delivery for the mothers. The form used for the infants continued monitoring activities until 12 months of age.^{6,7}

Comments/issues raised by Staff members

Concerns raised by the PMTCT coordinator included the possibilities of an increase in malnutrition in the infants born to the HIV positive mothers after they are told to cease breastfeeding after 4 to 6 months of age. Due to lack of food, inability to afford formula as an alternative to breast milk, and the unavailability of formula, she had observed mothers preparing millet meal and water to provide to their babies rather than breast milk. The coordinator was very concerned that malnutrition would ensue due to the lack of nutritional content of the millet preparation in comparison to breast milk..

Other challenges noted include a) the need to increase community mobilization to reduce denial, stigma, and discrimination; b) the need to implement realistic feeding modifications and make provision for replacement feeding when acceptable and safe; c) the need for increased social support with training programs involving more community based health care workers and volunteers; d) the need to make provision for a nutrition program to be an integral part of the whole package, i.e. making food available to those on ARVs who are unable to adequately feed themselves.

Staff members stated that they felt that the PMTCT plus program would serve as an impetus to get men to have HIV testing; and that the HAART program was needed. Additional work in the community to reduce stigma was reiterated by staff members.

Volunteer support for home based care is needed to assist patients in maintaining their medication regimen. There is currently no hospice program in place. The issues of pain relief and spirituality also need to be addressed. Oral morphine needs to be made available for those who are dying from HIV/AIDS at home. Hospice care, nutrition, and water programs need to also be included when addressing the treatment, care and support of HIV/AIDS patients. Uniting with the European Union may assist in addressing these needs.

⁶ CHS:PMTCT Follow-up Protocol – Baby.

⁷ CHS: PMTCT Protocol – Mother.

Impression/Assessment # 1: Compliance with HIV counseling and testing

During the last ten months, St. Mary's Hospital had a 100% adherence to HIV counseling and testing for pregnant women.

Recommendation:

1. Have St. Mary's share with other programs the methodology they used to get 100% compliance with HIV testing.

Impression/Assessment # 2: Need for re-evaluation of home visitation program and needed staffing

There is a home visitation program that provides weekly home visits to all the HIV+ women and their infants for the first six weeks following birth. The home births provide close monitoring of the infant for presence of thrush, coughing, diarrhea, fever, and feeding.

Recommendation:

1. As the HIV positive caseload grows, there may be the need to re-evaluate the feasibility of conducting weekly home visits for the six week postpartum period. Should the decision be made to continue the home visitation program, additional workers will be needed.

Impression/Assessment # 3: Visible service delivery guidelines for labor and delivery

St. Mary's Hospital has service delivery guidelines for service providers to decrease mother to child transmission of HIV during labor and deliver. These guidelines are posted on a bulletin board that is accessible and visible to all service delivery personnel.

Impression/Assessment # 4: Lack of follow-up for mothers who are HIV negative

There does not appear to be any repeat HIV testing of those women who were found to be HIV negative on the initial test. In that the HIV prevalence rate is between 10% and 43%, there can be an increased incidence of positive HIV test results if the HIV test is repeated in 3 and 6 months.

Recommendation:

1. For women whose initial test results are HIV negative, recommend counseling for f/u HIV testing at three to six months after the initial HIV test due to the high prevalence of HIV in Rehoboth.
2. Suggest an additional checklist to provide medical surveillance for opportunistic infections at the six week postpartum visit to ensure that there are no symptoms of HIV that may have developed since the last testing was completed.
3. Recommend that enrollment in the PMTCT program be expanded to include all women who consent to be tested for HIV/AIDS. Rationale is that further monitoring will continue to be needed for HIV negative mothers due to the high prevalence of HIV in Rehoboth. While the mother may not be HIV positive, there continues to be the need for monitoring the HIV status in another 3 months to assure negative results during pregnancy. Therefore all women who choose to be tested should be enrolled in the PMTCT program until follow-up testing at 3-6 month after the initial test has been completed and negative HIV test results are confirmed.

Impression/Assessment # 5: Appearance of lack of infection control program and guidelines

While there were service delivery guidelines for use in labor and delivery, there were no infection control guidelines that would utilize universal precautions for personnel to reduce the risk of infection transmission (HIV/AIDS, Hepatitis, and other infectious diseases) to the workforce.

Recommendation:

1. Contact JHPIEGO or EngenderHealth for their information re: infection control for low resource settings. Both organizations have curricula and instructional material for establishing infection control practices in the workplace.

Impression/Assessment # 6: Need for modification to current counseling re: breastfeeding for HIV positive mothers

The current protocol for breastfeeding practices is based on the WHO Breastfeeding and Replacement Feeding Practices in the Context of Mother to Child Transmission of HIV. However, there remains a concern for infant malnutrition due to lack of appropriate replacement feeding options being available. As per the WHO notes that “breastfeeding should continue for 6 months and then replaced with suitable breast substitutes, and complementary foods made from appropriately prepared and nutrient-enriched family foods, given three times a day. If suitable breast milk substitutes are not available, appropriately prepared family foods should be further enriched and given five times a day”.⁸ The importance of available enriched family foods needs to be captured as assessment of infant counseling and feeding is done to ensure an optimal nutritional environment is available for the infant after six weeks of age.

Recommendation:

1. Written information on feeding options along with information on incidence of HIV in infants breastfed for 6 months and after should be provided to the mother and her family so that informed choices can be made regarding infant feeding practices.
2. If the following source has not been available to staff, conduct additional training on with WHO’s publication “HIV and Infant Feeding Counseling: A Training Course” which can be located at the following website. This website includes a training and participant manual.

<http://www.who.int/child-adolescent-health/publications/NUTRITION/HIVC.htm>

Impression/Assessment # 7: Lack of evidence of family planning services integrated into PMTCT program

While family planning services existed at St. Mary’s Hospital, there was no evidence that family planning counseling, referral, and/or family planning service were integrated into the PMTCT program.

⁸ http://www.who.int/reproductive-health/publications/RHR_01_12/RHR_01_12.en.abstract.html

Recommendations:

1. Family planning counseling can be included in the group counseling sessions that occur in the antenatal clinic for all women and their families.
2. Family planning referral and/or service delivery should be an integral part of the PMTCT program.

Impression/Assessment #8: Lack of patient education materials; job aids

No patient education materials were seen for HIV, family planning, ARVs.

Recommendations:

1. Patient education materials (and job aids as needed) be developed for the following:
 - a. HIV high risk behaviors; HIV testing
 - b. Family planning methods
 - c. Feeding methods and information on HIV transmission rates with breastfeeding
 - d. nevirapine and ARVs for treatment of HIV in pregnancy

St. Martin's Hospital, Oshakuku, Namibia**Informants:**

Dr. S.O. Awe – Principal Medical Officer

G. Andowa – PMTCT Coordinator

Sr. Raphaela Handel – Executive Director, Catholic Health Services

St. Martin's Hospital, under the administration of Catholic Health Services, is one of the district hospitals for the Ondongwa region with a catchment population of 96,529 people. Besides the hospital, there are 16 clinics, two health centers and 22 outreach points served by mobile clinics. Staffing at the hospital consists of 6 physicians, most who have been trained in HIV management. There are approximately 50 to 60 births per month with 2 to 3 births (4%-6%) being to HIV positive mothers. Eighty percent (80%) of the TB patients are HIV positive.

The PMTCT Program at St. Martin's Hospital.

In August, 2002, the PMTCT program was initiated at St. Martin's Hospital. Group counseling is done during the prenatal period at which varied topics are discussed including HIV/AIDs and the PMTCT program. Upon completion of counseling re: HIV/AIDs, women interested in being tested for HIV/AIDs go to a separate waiting area for individualized counseling and testing with test results being provided at the next visit.

Topics covered during group counseling and pre-test counseling include prevention of HIV; prevention of MTCT; breastfeeding; the importance of HIV testing; negative living; positive living avoidance of casual sex and alcohol; family planning and avoidance of future pregnancies; shared confidentiality; ARV prophylaxis.

Upon obtaining HIV/AIDs test results, post test counseling is done and includes a review of HIV, information on HIV prevention; HIV transmission; and other topics appropriate to the test result.

Should a woman test HIV positive, a code is written on the patient's card which will identify her as being HIV positive. Subsequently, at 34 weeks gestation, the woman receives two tablets of nevirapine and her card is reviewed against the time of delivery by the midwife. If her code determines that she is HIV positive, nevirapine is given within 72 hours postpartum to the child. Due to initiating prenatal care late in pregnancy, some women who have been tested for HIV do not have their final test results prior to delivery; these women do not receive nevirapine in labor.

There is a form for follow-up which is completed for those women who test positive for HIV. There are no home visits between hospital discharge and the 6week postpartum visit. Women are instructed to breastfeed their infants for 4 to 6 months after which time the infants are to be started on regular food.

At six weeks postpartum, the mother and child return to the clinic for their physical evaluations. Bactrim is given to the infants for prophylactic treatment and women desiring family planning are initiated on a family planning method. Most of the 25 positive HIV women who delivered went for family planning follow-up.

Currently, there is only symptomatic treatment for HIV/AIDS. In Oshakati, the ARV program has just started. St. Martin's hospital has been asked to sensitize the community about the ARV program that has been initiated at Oshakati hospital. However, the supply of ARV prophylaxis is problematic right now in Oshakati. It is thought that having ARV medications would be a motivating factor for women to get HIV counseling and testing and it would make a difference with the issue of stigma.

Outcomes of the PMTCT Program

Between August, 2002 through August, 2003, 647 women presented for their first ANC visit. Sixty nine women (11%) received pre-test counseling and testing for HIV/AIDS. Twenty-three (33%) were found to be HIV positive; 27 (39%) were HIV negative; three (4%) test results remain pending; and there is no information for 16 tests(23%) that were conducted. Only 18 (26%) of the 69 women who had HIV testing returned for test results and post-test counseling. Since August, 2002, 32 women have been registered in the PMTCT program. A total of 26 women received Nevirapine in the delivery room; none received nevirapine prior to delivery. St. Martin's Hospital has a domiciliary where women can come to stay from 34 weeks until delivery. Of the 26 women who received nevirapine in the delivery room, 25 women were enrolled in the antenatal PMTCT program and 1 woman who had not enrolled in the program prior to delivery.

Twenty three infants (88.5%) received nevirapine syrup after delivery; three infants (11.5%) died; four infants (17%) continued in follow-up and received co-trimoxazole prophylactic therapy at six weeks post delivery. Only two of the four infants (50%) who continued in follow-up were tested at 12 months after birth. One infant was found to be HIV positive; the other infant was HIV negative. There is no recording of infants being tested at 9 months of age. These findings indicate that only 4 infants (17%) whose mothers tested HIV positive during pregnancy continued to be monitored after delivery and, only two (8%) of these infants were tested at 12 months following birth.⁹

The rationale given for women who did not choose to be tested for HIV/AIDs and for women who did not return for their test results included:

⁹ CHS PMTCT Monthly Report – Oshikuku Hospital August 2003.

- a. Women are questioning why drugs are being provided for the child but not for the mother. They felt that if the mother died, there would be no one who would take care of the child whereas if the mother remains alive, she can try to make sure that the baby has what it needs.
- b. It was also questioned whether there has been a breach of confidentiality by hospital staff creating a lack of trust in the community. It is said that people in the community wonder how it is known that individuals in the community have HIV. Therefore the cause of low numbers may be related to the women's lack of trust of the hospital staff.
- c. It was felt that attitudes of the hospital staff towards HIV needed to be changed. There is the need to sensitize hospital staff about stigmatizing language; that it is not a sin to have HIV.

Staffing

Staffing for the PMTCT program includes the PMTCT Program Coordinator, ten Catholic AIDS Action volunteers, and one physician who has completed training in HIV management. Currently group and individual counseling is conducted by lay counselors. Patient caseloads (inpatients and outpatients) for the counselors range from 75 to 200 patients per month.

Initially, after completing a 3 day training workshop, the nursing staff provided the HIV/AIDS pre and post-test counseling. This practice ended due to lack of interest by the nursing staff for continuing this work. Catholic AIDS Action was then approached to provide counselors.

The first set of volunteers provided by Catholic AIDS Action provided HIV counseling for some months and did great work but they left due to monetary issues. Their initial salary was US \$26/week (US \$102/month) but it was felt that this salary was too high. After the counselors left the numbers for HIV counseling and testing decreased. There was the request for more counselors to be trained. Another set of counselors was obtained through Catholic AIDS Action and they were paid US \$14/month, 14% of the salary received by the first set of counselors.

The person serving as the PMTCT Coordinator is a nurse who is also assigned to the maternity ward. However due to staffing shortages, she does not have the time to go to the outreach points.

There has been difficulty in getting positions for the District PMTCT Coordinator and two nursing positions filled for the HIV program. Advertisement was made for the District PMTCT Coordinator. To date no responses have been received. While this position requires additional hours and responsibility, monetary and job security issues do not make the position attractive to nurses currently working in the ward. They include: a) the position does not provide any additional monetary allowance as is offered for nurses working on holidays or Sundays; b) there is a salary increase in the pipeline for all nursing staff, there is no guarantee that the increase will apply to the District PMTCT Coordinator position; c) there is no job security once the funding for this position has ended; one cannot be guaranteed that they can return to the government or Catholic Health Services personnel system and/or maintain their tenure for retirement once the grant funded position has ended; d) this is a key position that needs more job autonomy so that necessary community work could be done to dispel myths regarding HIV/AIDS; e.) the position is seen as one with additional responsibilities and hours, but without additional pay over what a nurse currently is receiving working on the wards, and without the ability to earn overtime pay. Therefore there is no incentive to take the position. It was

felt that if the advertisement included an additional allowance, then there would have been responses to the advertisement.

Monetary issues that effect the ability to hire for the two HIV positions include a.) a differential of three times the base pay for nurses who work the wards on Sundays; b.) differential of double the base pay for nurses who work the wards on holidays. These differentials occur even when these hours fall within the usual 40 hour work week; c.) no overtime pay or differential pay for nurses who work additional hours during the week; d.) a mixture of employers (government and Catholic Health Services) which affects the ability to detail staff to other assignments and determine the ability for a nurse to receive differential pay.

Training

While the HIV/AIDS counselors are being trained by Lifeline/Childline it was felt that it would be very crucial that the physician and nursing staff working in the ANC, maternity, and family planning areas have general training in HIV counseling. More specific training is needed for HIV management and ARVs. To date only one nurse has completed this training. There is uncertainty if additional training workshops will occur.

No counseling is available for patients presenting for evaluation of sexually transmitted infections in the medical clinic due to the lack of qualified counseling personnel. HIV/AIDS testing cannot be done in this area due to this.

Infection Control

There is an Infection Control Committee but it has not functioned for some time. At present there are no infection control protocols in place. There is a new incinerator for disposal. Also there is ARV prophylaxis available for the staff.

Communications

HIV is considered the disease of “sinners”. Many people are afraid. Husbands feel that there is no one that they can tell. Men may have seen a girlfriend or one of his children outside of the marriage die, so he is afraid that he may be positive. One counselor felt that people desiring to have children should have HIV testing before pregnancy.

One can reach the community if HIV related topics are broadcast over the radio. On the local radio, there is a program where people are invited to talk, but it is not a call-in program. It would be more effective if it could be a call-in show where one could have their questions answered during the show. However, it was also felt that phone-in programs will only work for those who have a phone.

Another way to reach people is through village health committees. In each area that has a clinic and a village health committee. Some committees also have women representatives. It would be important to have meetings with each village health committee. They are very inquisitive; one can get through to them easily.

Women's Responses

An interview was held with the women who were receiving group counseling in the ANC clinic. Questions regarding VCT, nevirapine, and how to get men tested were asked. Their responses were as follows:

When asked why they would choose not to get HIV testing, responses were:

- Fear of husband – husband would say that they gave them the disease
- Afraid of the results
- Testing with husband (having the husband be tested along with the wife) does not solve the problems within the family
- Men need to be tested. It would be best for the men to come to be tested

When asked about what could be done to get the men tested responses were:

- Conduct meetings through the villages
- Launch a campaign to tell the men that the men are needed to go for the test
- Have meetings in the communities
- ARV prophylaxis needs to be available

When asked about their thoughts about Nevirapine, responses were:

- Heard about it
- Think it would help
- For one woman – she wants to get the test done but is afraid, however decided it is better to go for the test.
- One woman stated that she would commit suicide if her test result was positive
- Concerned that HIV gave her high blood pressure
- See a positive result as the end of her life
- See that she is no longer useful in the society. Not getting up from the bed because you are useless

When asked what they would want me to convey if I could be their voice in Washington, the response was:

- Send the ARVs to help them. It would be good. They would not mind that.

In that women were generally positive about taking nevirapine, they were asked why they chose not to go for HIV counseling and testing. **The women stated that they did not want to go from group counseling to a separate waiting room to get individualized counseling and testing; moving to a separate waiting room and sitting there marked them out as possibly being HIV positive.**

Observations

A tour of the hospital facilities was done and included the antenatal area, labor and delivery, postpartum ward, TB wards, the casualty ward (emergency room), the VCT counseling office, and the laundry department. The following was noted. Group counseling in the antenatal clinic was done in a large open room wherein vital signs, weights and venipunctures for lab tests are being done concurrently. Women who arrived during the group counseling had their weights and blood pressures taken in the same room. While there is another room connected to this room, it was not utilized for seeing patients. The manner in which the rooms were utilized made it impossible to have confidential interactions between the individual patient and the nursing staff.

Nurses wore gloves during venipuncture procedures. There was proper disposal of needles and syringes in hard plastic containers. Disposal of gloves used for venipuncture was in regular trash bags rather than bags that were identified for biohazard disposal. This made it impossible to identify contaminated trash from regular trash.

The antenatal clinic, labor and delivery and postpartum area was found to be clean. Guidelines regarding care in labor and delivery to prevent HIV transmission were posted on a bulletin board allowing access by all staff members. Trash cans used for disposal of trash in these areas also did not have separate trash bags that would identify biohazardous materials for disposal.

The VCT counseling area was a separate office that allowed confidentiality for the patient undergoing pre and post-test counseling and HIV testing. Each counselor maintained a separate log book that contained information on the patients they had counseled without divulging the patients' names.

The TB ward was severely overcrowded. Wards meant to have six individuals had 10 to 11 patients consistently throughout each ward. No isolation procedures appeared to be in place. Neither the staff or patients wore protective masks. Patients were on mattresses on the floor with bedpans sitting on the floor next to their mattresses. Due to the overcrowded conditions, there was limited space between mattresses. There were not enough curtains to pull around all patients, especially those whose mattresses were situated in the middle of the room due to lack of space. This greatly compromised any patient privacy, confidentiality, and basic human dignity. Family members who were present to provide support were cramped into the space between mattresses.

The casualty area was also very crowded. However, rather than patients being on the floor, their mattresses were on bed frames. It was stated that many patients presenting in the casualty area were HIV positive. A nurse working in the casualty area failed to wear gloves when starting an intravenous line risking exposure to a possibly contaminated needle. While plastic containers were present for sharps disposal, the trash can liners did not have special liners that identified the trash as being biohazardous material that would need to be disposed of in a special manner.

There was adequate supply of sterile needles, sterile syringes, and gloves for staff use. No patient education materials were seen on any of the wards.

In the laundry department the staff stated that they separated dirty laundry from clean laundry. Rather than separating laundry that came from the TB unit or labor and delivery, "dirty" linen was separated by sight. Laundry from these areas is prone to have an increased possibility of contamination due to blood, amniotic fluid, and other body fluids. Sticks are used to wash laundry that had visible blood. The staff also wears gloves, rubber aprons and boots when washing blood stained laundry. However there is no special solution used for decontaminating or washing blood stained linen. There were two washing machines present in the laundry area. Laundry from surgery is separated and washed in a different washing machine. Blood stained laundry from other wards is washed with other laundry in another washing machine after having been washed in a separate tub using sticks.

Other Concerns/Issues:

Other issues and concerns voiced by the staff included the following:

- a. The staff is looking forward to the PMTCT Plus program. They feel that it is needed to lift up the morale of the patients.
- b) A mobile unit (4x4 with double cabin) is needed for community mobilization, tracing clients, and for the PMTCT Coordinator to do home visits and ongoing

community mobilization. c) There was also concern regarding how to integrate PMTCT with the VCT centers. d) It is felt that more washing machines and staff are needed for washing hospital laundry.

Impressions/Assessments #1: Staff commitment in light of staffing shortages and pay difficulties

St. Martin's Hospital staff is to be commended for their commitment to the communities that they serve in spite of staffing shortages and payment difficulties.

Impression/Assessment # 2: Different employers/inequities in differential pay for nursing staff

1. There are different employers for the staff at St. Martin's Hospital. This impacts the ability for staff to earn differential pay and the ability to detail staff to where they are needed.

2. Salaries are impacting on the ability to hire nurses and counselors.

3. Inequities in pay for working overtime during the week vs. on Sunday makes it difficult to have staffing when needed during the busier times during the week. It also impacts on the hiring of competent staff for HIV/AIDS program and the PMTCT program.

Recommendations

1. Evaluate the pay schedule and make it equitable for all staff in each cadre regardless of the employer. Different pay schedules, and the ability to earn overtime or differential pay as well as inability to be detailed based upon employer reduces staff morale; lack of supervisory control, and staffing shortages in different locations in the hospital.

2. Utilize creative scheduling patterns within utilizing working 4,8, and 12 hour work shifts. While there may not be an increase in pay, creative scheduling may assist in obtaining staff satisfaction and coverage in areas where there may be more acute staff shortages.

3. Have all nurses do rotating shifts and cover holidays and weekends making it mandatory to work a certain number of holidays and weekends. This will allow all nurses to have the opportunity to earn additional pay when working on their scheduled holiday or weekend.

4. Create a career ladder within the current pay schedule. This would award nurses with seniority and additional specialties and certifications.

Impression/Assessment # 3: Lack of confidentiality in the antenatal clinic

Impression/Assessment # 4: Loss of confidentiality and patient dignity in TB wards, casualty areas

The following findings and recommendations address both Impression/Assessment # 3 and #4. Having group counseling in the same room that vital signs and weights are done in the antenatal clinic greatly jeopardized confidentiality. While confidentiality is stressed by USAID, WHO and

others for HIV/AIDS counseling and testing, this is not carried through to patient care areas. Currently the inpatient areas greatly compromise patient confidentiality and personal dignity

Recommendation:

1. Utilization of the space to maintain confidentiality could be done by a) using the second room for individual counseling and completion of vital signs and weights; or b) construction be done to divide the large room into a waiting area that can be used for group counseling and a nurse's office wherein vital signs, lab work, and counseling can be done with each individual thus allowing confidentiality.
2. Construction of additional patient care areas that would allow for adequate space for patients and family members wherein confidentiality and personal dignity is not sacrificed and compromised.

Impression/Assessment # 5: Lack of adequate infection control practices

Hospital wide there was lack of infection control practices being used. While there is an infection control committee, it is currently not functioning. While ARVs are available for the staff, universal precaution policies which should be the first line of defense in protecting staff against HIV do not exist. There appears to be adequate supplies; however there appears to be a lack of understanding by staff re: hospital wide precautions that need to be taken. This was evidenced by the following: there were no special trash bags that identified biohazardous trash used in any of the patient areas (TB ward, maternity ward; casualty area); a nurse placing a bloody angiocath from a discontinued IV into a plastic container without wearing gloves; only separating laundry from the theater, but not laundry from other areas where HIV/AIDS patients are cared for.

Recommendations:

1. A vigorous infection control program for the entire hospital would also be helpful in providing protection of the workforce from HIV/AIDS. Having ARVs for the staff is not enough.

Impression/Assessment # 6: Stigma poses a major barrier to an effective PMTCT program

Women in the antenatal clinic very clearly stated that they refused individualized counseling because they would have to separate themselves from the group to obtain individualized counseling. Sitting in a separate waiting room marked them as being perceived as possibly having HIV/AIDS. Only 69 (11%) of 647 women who presented for prenatal care received pre-test counseling and testing for HIV. Only 18 (26%) of the 69 women who had HIV/AIDS testing returned for test results and post-test counseling.

Recommendation:

1. While an opt-out policy for HIV testing will be used in Namibia, there still needs to be a change in patient flow to allow for anonymity and confidentiality for HIV counseling and testing and the opportunity to opt-out of HIV testing. Perhaps all the information provided in individualized counseling can be included in group information. A separate room is needed that that will allow confidential conversation between the patient and provider for more in-depth counseling and decision making regarding HIV testing.

2. A vigorous community based education program is needed. As per statements offered by the women interviewed, stage community meetings throughout the villages; with particular emphasis on programming to get men tested
3. Hospital wide education on HIV is needed for all staff to improve staff attitudes and perceptions of people with HIV/AIDS. Review of Namibia's confidentiality policy should be a part of the training.
4. Provide mobile unit(s) as requested for increased access to the communities. This will allow for follow-up by the PMTCT Coordinator and community education.

Impression/Assessment # 7: Lack of adequate staffing to provide necessary patient follow-up in the PMTCT program

The PMTCT Coordinator is currently assigned to the maternity ward as well as serving as the program coordinator. Staffing shortages reduces her ability to go to outreach points. Due to lack of qualified counseling staff in the medical clinic, HIV counseling does not occur. Twenty three infants received nevirapine syrup after delivery, with only four infants (17%) continuing in follow-up. Only two of these infants had HIV testing at 12 months of age.

Recommendations:

1. The PMTCT Coordinator needs to be released from duties on the maternity ward so that she can provide necessary staffing and oversight to the PMTCT program.
2. Additional staff needs to be hired for home follow-up of mothers and infants after delivery so that most enrolled in the PMTCT program will continue for 18 months.
3. A twinning relationship with a US University that has social services, nursing, and medical departments would be helpful in providing staffing and educational resources to the PMTCT program.
4. Due to the incidence of HIV among TB patients, and the questionable supply of ARVs available in Oshakati, would recommend initiating a HAART program at St. Martins Hospital.

Onandjokwe Lutheran Hospital – Ondangwa, Namibia

Informants:

Mr. John Lumbu – HIV/AIDS and STD Coordinator

Dr. Jeroen van Dillen – Medical Director, Obstetrics and Gynecology

Ms. Rauna Himbode – Home Care/ STD Counselor

Mr. William Akwaake – TB Coordinator

Dr. Aammambo – Chief Medical Officer

In response to the increasing HIV epidemic in Namibia, in 1999 the Evangelical Lutheran Church in the Republic of Namibia (ELCRN) Synod established the Evangelical Lutheran Church in

the Republic of Namibia AIDS Programme (ELCAP). ELCRN determined that a comprehensive approach to HIV/AIDS should be taken with a focus on caring and counseling for persons infected with HIV/AIDS; special care and support of orphans and families affected by HIV/AIDS, prevention of HIV/AIDS through awareness raising and education; outreach to all congregations, institutions, farms, communal and mining areas where ELCRN exists and beyond; and networking with existing organizations to accomplish these goals.¹⁰

Onandjokwe Lutheran Hospital which is under the administration of the Evangelical Lutheran Church in the Republic of Namibia (ELCRN) is a 450 bed semi-rural, semi-private mission Hospital in Northern Namibia with a catchment area of approximately 170,000 people. It serves as the district Hospital and the referral Hospital for two smaller hospitals. It also houses the headquarters for all district health activities including the offices of the district PHC team. Onandjokwe Hospital has 12 clinics in a 60 to 120 km radius and 40 to 50 outreach points. Services include primary care including prevention and health promotion; OB/GYN services, pediatrics, internal medicine, and surgery. Emergency intensive care is provided when needed. Outpatient services include primary care, antenatal care, HIV/AIDS and STD services and immunizations. Onandjokwe hospital has 250 to 300 births per month; 3500 births per year, making it one of the busiest obstetrical services in Namibia. In 2001, Onandjokwe found that its maternal mortality rate was 270/100,000. Of the 21 maternal deaths during 2001, 76% were possibly HIV related and 57% were proven HIV positive. Most of the deaths occurred in the 26-35 year age group (66%), para 1 to 4 (50%) with 61% of the deaths occurring during the puerperium (6 weeks following delivery), mostly following chronic illness.

In response to this data, during 2002 a small pilot study addressing patient acceptance of HIV testing was conducted. In the ANC department, 168 patients were asked how they would respond if HIV testing would be made available as a routine test during antenatal visits. Ninety eight percent (98%) of the ANC attendees stated that they would do the test with 83% desiring to know the results of the test. During May 2002, a few events highlighted the possibility of using Nevirapine for the prevention of mother to child transmission of HIV at Onandjokwe Hospital. Private patients who were referred to the hospital for delivery had received nevirapine for use during labor. Also, the cost of nevirapine was found to be highly affordable at US \$0.86 (ND 6) per 200 mg tablet excluding VAT. In June, 2002, the Regional Medical Director agreed to allow patients to buy nevirapine at a private pharmacy. Emphasis on voluntary counseling and testing would have to occur but mass treatment would not be allowed in Namibia nor would the hospital be allowed to purchase Nevirapine. Women could also be sent to Oshakati Hospital for inclusion in the PMTCT study. Participation in the study would provide free nevirapine to patients if they and their husbands presented for voluntary counseling and testing¹¹ Announcement of this study at Oshakati hospital in the national news prompted increased awareness among the women coming for prenatal care. They were asking many of the staff about the issues of HIV in pregnancy. As a result of these events, in 2002 the Department of Obstetrics and Gynecology wrote Guidelines for Pregnancy and HIV along with patient education

¹⁰ Evangelical Lutheran Church in the Republic of Namibia AIDS Programme (ELCAP) Current and Proposed Programmes August 2003.

¹¹ Onandjokwe Lutheran Hospital Department of Obstetrics and Gynecology Guidelines Pregnancy and HIV.

²³ Onandjokwe Lutheran Hospital Department of Obstetrics and Gynecology Guidelines Pregnancy and HIV.

materials in varied languages to educate patients about the prevention of mother to child transmission and the option of nevirapine use.¹²

Findings of the 2002 Annual Report of the Department of Obstetrics and Gynecology at Onandjokwe Hospital

The 2002 annual report of the Obstetrics and Gynecology department provides interesting data regarding the status of women's health in the community served by Onandjokwe Lutheran hospital as well as staffing levels at the hospital.

Status of Women's Health

During 2002, 1070 women presented for their first prenatal visit, with 684 (65%) initiating care between 16 and 28 weeks gestation. Hemoglobin levels were > 10 gm/dl for 93% (997) of the women; 98% tested negative for syphilis. There were 1040 postnatal visits representing the possibility that 97% of the women returned for postnatal care.

Gynecological disorders that gave rise to hospital admission included sepsis as the fifth most common cause for hospital admission. Investigation was the most common cause for gyn admission. The presence of foreign body was stated for three admissions. Respiratory tract infections (which included pharyngitis, pneumonia, and tuberculosis) and incomplete abortion were the two most common obstetrical diagnoses that required hospital admission. Threatened abortion in the first trimester; incomplete abortion, missed abortion, and threatened abortion in the second trimester accounted for 425 admissions. Of the 1063 surgeries that occurred, the most common reasons included cesarean section (25%); D&C (25%) and laparoscopic bilateral tubal ligation (13.5%).

Of the 434 admissions to the antenatal care unit, 10% (45) was due to malaria; 5% (25) was due to pneumonia/tuberculosis; and 1% (3) was due to an immune compromised state.

Most striking is the data regarding maternal mortality. During 2002, there were 3555 deliveries and 22 known maternal deaths that occurred during 40 days postpartum. Five deaths (23%) were due to AIDS; four (18%) were due to atypical pneumonia; three (14%) due to hepatitis; two (9%) due to malaria; two (9%) due to abortion; 2 (9%) due to eclampsia; and one (4.5%) due to abruption placenta. All in all, AIDS and atypical pneumonia, which may be an opportunistic infection secondary to HIV positive status, accounted for (41%) of all maternal deaths in 2002.¹³

The PMTCT Program at Onandjokwe Hospital

It is important to note that the PMTCT program that is currently in place is in response to careful monitoring of maternal mortality data and response to patient demand for nevirapine to prevent mother to child transmission of HIV. There was no funding for the initiation of this program. USAID funding for the PMTCT program will begin September, 2003.

¹² Guidelines Pregnancy and HIV Onandjokwe 2002 Prevention Mother to Child Transmission Patient Information Leaflet (English).

²⁴ Guidelines Pregnancy and HIV Onandjokwe 2002. Prevention Mother to Child Transmission Patient Information Leaflet (English).

²⁵ Onandjokwe Lutheran Hospital Department of Obstetrics and Gynecology Annual Report 2002.

¹³ Onandjokwe Lutheran Hospital Department of Obstetrics and Gynecology Annual Report 2002.

Group information re: availability of HIV voluntary counseling and testing and preventing mother to child transmission is given to women presenting for prenatal care in the antenatal clinic. The counseling department provides all counseling at the hospital for HIV/AIDS through the HIV/AIDS – STD department. OB patients desiring individualized counseling and HIV testing go to the counseling department for these services. Blood work is obtained for HIV tests, with post test counseling occurring at the HIV/AIDS – STD counseling department. If the test is HIV positive, the patient is referred to the gyn physician for nevirapine prescription which she has filled at a private pharmacy. Once funding is received to support the PMTCT program, nevirapine will be available free to HIV positive women. Pregnant women who are HIV positive are enrolled in the home based care program that is administered by the HIV/AIDS - STD Department. Home based care included pre and post test counseling, follow-up for HIV + clients; and support groups. At the six week postnatal visit, women are placed on a family planning method with a large number of women choosing bilateral tubal ligation as their method of choice.

Outcomes of the PMTCT Program at Onandjokwe Hospital

Between August 2002 through December 2002, 444 women presented for prenatal care. Forty (10%) of these women presented themselves for VCT counseling and testing. Twenty (50%) of the women tested positive for HIV/AIDS. Twenty women were referred to the gynecology department for nevirapine prescriptions; with 20 prescriptions being written. Nine women received nevirapine at the time of delivery.

From August 2002 though June 2003, there have been 35 prescriptions written for nevirapine with 25 women receiving nevirapine at the time of delivery.

Family Planning

Family planning is initiated at the six weeks postpartum visits. In 2002 there were 801 women who came for an initial family planning visit. On the initial visit 178 women (22%) chose oral contraceptives; 382 (47.7%) chose injectable contraceptives; 41 (5%) chose IUDs; and 200 (25%) sought advice only. 3460 male condoms were distributed in the Family planning clinic alone. The female condom was introduced in November of 2002, with 25 condoms being distributed. As per the nursing staff in the family planning clinic, there was great interest in the female condom, but they ran out of supplies. Many women chose to have tubal ligation as a means of ending the spread of HIV/AIDS. This was evidenced in the statistics for the theatre wherein 137 laparoscopic bilateral tubal ligations were performed in 2002 representing 13.5% of all surgeries done in 2002.

Staffing

Additional staffing is needed all around. When the PMTCT program starts, more counselors will be needed. Staffing levels noted in the 2002 Annual Report of the Department of Obstetrics and Gynecology is noted below. This staffing may represent those staff that are on the books but not necessarily available for work due to illness; reassignment; training, etc. Note that the staffing is for 24 hours a day, seven days a week.

Ward	Type of Staff	# of staff	average # of pts/day
ANC & FP	Senior Registered Nurses	2	46
	Registered Midwives	1	

Total for ANC/FP clinics	3
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Gynecology	Registered Nurses	3
	Registered Midwife	4
	Enrolled Midwives	2
	Enrolled Nurses	0
	Nurse Assistant	1
	Cleaners/kitchen/childcare	8

Total nursing staff – 10; cleaners/kitchen/childcare – 8

Obstetrics	Registered Nurses	15/16
	Registered Midwives	6
	Enrolled Midwives	1
	Enrolled Nurses	1
	Nurse Assistant	0
	Cleaners/kitchen/childcare	11

Total nursing staff – 24; cleaners/kitchen/childcare – 11

Gynecology Outpatient Dept	Nursing Assistant	2 (sometimes <u>only 1 on duty</u>)	# pts/day 43
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Total nursing staff – 1 to 2

OB/GYN Physicians	3 full time; four on call
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HIV/AIDS –STD counselors	4 (do outpatient, inpatient, and home based care counseling) ¹⁴
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Women's Responses

Interviews were held in a group setting for women who were present for prenatal care. There were greater than 55 women present and a total of five nurses, midwives and student nurses. Questions asked of the women related to VCT; what to do to get men tested, and how to get the message of HIV/AIDS out to the community. The responses are as follows:

The question regarding counseling and testing garnered the following responses:

- All women should be tested;
- Only give the nevirapine if the woman is positive; don't tell her the test results
- Concerned about illness caused by HIV
- There would be shock in finding out that you are HIV +

¹⁴ Onandjokwe Lutheran Hospital Department of Obstetrics and Gynecology Annual Report 2002.

- When having a simple headache would be concerned that it might be caused by HIV
- Would accept the diagnosis
- If you love your baby, you will get the test
- One stated that she would tell the people around her; protect herself and her partners; and would seek medical attention
- Using condoms
- Stigma is a big issue. **If you have HIV, people will call you names; when you are walking in the street they shout at you saying you are HIV+ and people should stay away from you.**
- One woman stated that she would commit suicide
- There is fear that you will be the laughing stock
- The husband blames the wife for getting HIV; she has infected the husband; violence then occurs; there are other wives
- Will the men get tested?
- Men should go to the counseling office also
- When asked if husbands should come with their wives to get tested for HIV, the response was that “you will get bitten” (if you ask the husband to come with the wife)

When asked what could be done to get the man tested responses were as follows:

- There should be a policy that every women and the father of the child be tested
- It makes a big difference for those who live with the father.
- Need someone educated to come and talk to the fathers
- Husband should come with the wife to the ANC to get information

When asked what was the best way to get the message out in the community, responses were:

- Meeting in the community; some cannot afford radios
- Radio is good, ones that have it can give information to the others

When asked what special message they wanted me to take back, the response was:

- Give them help to overcome this HIV/AIDS issue

Observations

During the field visit to Onandjokwe hospital, observations were made of a weekly meeting of the medical, midwifery, and nursing staff chaired by Dr. Amaambo; the HIV/AIDS –STD counseling setting; the maternity unit which included labor and delivery, antenatal high risk, delivery, postpartum and nursery.

At the medical staff meeting held by Dr. Amaambo the main issue at hand was the discussion of screening patients who were to be referred to Oshakati Hospital for ARV therapy. ARV guidelines for patient screening which had been compiled by the ARV Committee were presented. The guidelines included information regarding the forms to be used for staging patients based on symptomatology in accordance with WHO standards and patients with CD4 counts < 200/ml. Copies of these forms would need to be made for storage at Onandjokwe hospital; with the original copy being sent to Oshakati. The ARV team had reviewed the patient listing to ensure that patients listed

were eligible for ARVs at Oshakati hospital. Currently Oshakati was initially only accepting 6 patients from each referring hospital.

Requirements for eligibility for patient participation in the ARV program were discussed. One requirement was that patients would need to have a support person to be eligible for consideration for ARV treatment. Many questions regarding the issues of eligibility for participation in the ARV program were brought forth and included: a) what were the consequences for patients who were referred for treatment by Onandjokwe Hospital but refused by Oshakati Hospital?; b) what would be the criteria for refusing a patient for treatment? Many in the meeting felt that it would be discriminatory to refuse a patient treatment because they did not have a support person. Also, due to the changing numbers of patients being accepted into the ARV program at Oshakati, it was suggested that once the number of patients being accepted each week for treatment was determined then the medical staff at Onandjokwe should determine which patients would be referred for treatment rather than have Oshakati determine which patients would be accepted for treatment. This discussion raised much concern on the part of the staff as there are hundreds of patients in need of ARV therapy. It was felt that more treatment centers were needed and that the counseling department would need to be beefed up. Other comments were that family planning advice is needed to make ARV treatment more effective. Food and transportation is important for those working as supporter of the patients; would this be provided for the supporters? Other concerns raised at the meeting were the need to look at scheduling for the physician staff as they would be losing one physician. This would increase the workload of all until a replacement could be made.

The visit to the HIV/AIDS –STD Counseling Department showed a very large office. The office consisted of one very large room which housed the desks for the STD counselor and the Director of the HIV/AIDS- STD Counseling Department as well as kits for the home visitation program. The staff was very concerned with maintaining patient confidentiality. Due to the office layout, it was necessary for either the STD Counselor or the HIV/AIDS STD Director to leave in order to allow patient counseling in a confidential manner. Depending on the workflow, this could be extremely disruptive to one or the other persons, thus making their workday more inefficient. Patients waiting to receive counseling either for STD or HIV/AIDS sat outside on chairs that had been provided.

The antenatal ward that was meant for 6 patients had 11 patients there. Diagnoses include preterm rupture of membranes; placenta previa, and HIV. Infection control guidelines were not up on the board with other protocols/guidelines. Nurses stated that they wore goggles at deliveries and used boots during delivery for increased bleeding. They were aware that episiotomies should not be cut unless needed. However, verbal reporting from another midwife noted that gloves are not worn when deliveries are being conducted; forceps were not used doing suturing of episiotomies; gloves were not worn when starting IVs or drawing blood.

There was an appropriate disposal container for sharps. Red bags were present in the trash cans in these areas. When asked about the red bags, the head nurse responded that it was to ensure proper handling and discarding of the waste. An incinerator is used to burn the trash. There were two beds in the hall way for women in early labor as there was not enough room for them in the ward. Bathrooms and showers were in separate compartments allowing privacy for the individual. There was a single delivery room available for private patients who wished to have their husbands with them during labor and the birth of their babies. While the mattresses in the labor and delivery areas were covered with clean linen, it was noted that the mattresses had dried blood on the surfaces.

In the visit to the outpatient antenatal and family planning clinic there appeared to be only one exam table for prenatal patients and family planning patients. It was in the same room as the nurse's office with a screen to provide separation between the nurse's desk, patients that were being counseled, and the exam area. This arrangement greatly inhibits confidentiality for the patient.

Housing for the physician staff was on the grounds of the hospital allowing patients easy access to the physician staff. During the visit to Onandjokwe Hospital, adequate space and the lack of nursing and medical staffing was keenly felt and observed. Meetings with Dr Amaambo and Dr. van Tillen occurred over a lunch period. A meeting with the Director of the HIV/AIDS – STD Counseling Department was arranged around patient appointments as the Director had a patient caseload due to decreased staffing levels.

Other comments/issues

It was felt that programming for the PMTCT program needs to encourage partnership and also have flexibility so that the needs of the community can be met. Often donors are not willing to support the building of infrastructure (i.e. Buildings), but seem to be more geared to human capacity building. While this may be a good idea, it may not be the best use of monies. Training is expensive and one cannot ensure that training will produce the outcomes that are needed. This may be due to the wrong persons being trained, people leaving after training has been completed. It is felt that if money is used to build facilities, then the ward/facility will be there much later and still being used for the intention for which it was built. Onandjokwe Hospital is in need of additional space as well as additional staff. Other centers for VCT need to be identified in the catchment area. The vision is that in the future, larger clinics in the community can be visited by the MDs from Onandjokwe Hospital. It is also hoped that once PMTCT gets started that the program will branch out and be a clinic all its own wherein they will be the "experts" in PMTCT.

Impressions/Assessment #1: Use of statistical data in the OB/GYN department to provide program planning.

Onandjokwe Hospital is to be lauded in its monitoring and evaluation of its OB/GYN program. This oversight brought about the initiation of a PMTCT program without any funding as a response to the increased incidence of HIV positive women in its caseload. Also they listened to the women they served by seeking out pharmacy services and the necessary authorization to initiate voluntary counseling and testing and the provision of prescriptions for nevirapine to curb the incidence of maternal to child transmission of HIV.

Impression/Assessment # 2: Need for Onandjokwe Hospital to have a HAART program and be a center of excellence for the PMTCT program in Namibia

Onandjokwe Hospital has the physician staff with the knowledge base needed to provide and oversee a HAART program. The current arrangement of having to decide which patients should be referred for treatment at Oshakati places the staff in a great ethical dilemma. The lack of HAART medications at Onandjokwe places the staff in the position of deciding who should or should not receive HIV/AIDS treatment. The maternal mortality rate related to HIV and HIV-related conditions is very striking (approximately 41% of all maternal deaths).

Recommendation:

1. Onandjokwe Hospital has one of the largest OB/GYN services in Namibia. They should be developed as a core program for HAART and a center of excellence for HAART programs for women.
2. A HAART program for everyone should be initiated as soon as possible at Onandjokwe Hospital.
3. Until the HAART program is available, nevirapine needs to be purchased for the hospital for use in the PMTCT program.
4. Counselors need to be placed as soon as possible in the following areas to assist in HIV/AIDS counseling and testing – family planning clinic, medical clinic, STD clinic.
5. PMTCT programs should be expanded to include women seeking gyn care, STD care; medical treatment.

Impression/Assessment # 3

There are high rates of interventions that appear to be related to unsafe abortion and/or miscarriage. They include the following: 25% of all surgeries are D&C; sepsis is the fifth most common cause for hospital admission; investigation was the most common cause of hospital admission; threatened abortion in the second trimester; missed abortion; and incomplete abortion accounted for 425 hospital admissions; 10% of all admissions to the antenatal care unit was due to malaria; two (10%) of the maternal deaths was due to abortion. All of these indices are indicative of a high rate of miscarriage (spontaneous abortion) or unsafe abortion.

Recommendations:

1. Further surveillance/evaluation of these indices in other hospitals to evaluate incidence
2. Initiate a postabortion care program at Onandjokwe Hospital

Impression/Assessment # 4

Guidelines regarding infection control were not posted for staff to see. There was inconsistency in reporting regarding the use of universal precautions in the workplace. However, there was evidence of knowledge of universal precautions via use of red trash bags to identify biohazardous waste material and citing the use of aprons, gloves, mask for delivery.

Recommendations:

1. Assessment re: the presence of a hospital wide infection control program is needed.
2. If there is no hospital wide infection control program in effect, recommend institutionalizing a hospital wide infection control program with proper and adequate supervisory oversight.

Impression/Assessment # 5

Staffing and space are major issues affecting the ability to provide care.

Recommendations:**Staffing:**

Please note remarks made under St. Martin's Hospital

Space:

1. Please note remarks made under St. Martin's Hospital re: need to have adequate space in patient care areas to provide confidentiality and patient dignity.
2. Additional physical space is needed for offices. One option is to renovate the HIV/AIDS & STD Counseling area to have individual offices and inside waiting area for patients as well as storage area for supplies

Impression/Assessment # 6

Bilateral tubal ligation makes up 13.5 % of all surgeries. Female condoms were introduced in November 2002 with 25 condoms being distributed in a 2 month period. Nursing staff stated that women desired the female condoms, but the clinic ran out of female condoms.

Recommendation:

1. Ensure that informed consent is being utilized for women choosing bilateral tubal ligation
2. Consider including female condoms on the required list of supplies/medications to ensure continuous availability of female condoms.

Interviews**Katatura Hospital - STD/HIV Clinic****Informant:**

Dr. Flavia Mugala – Medical Director – STD/HIV Clinic

Katatura Hospital has two testing sites for HIV/AIDS as well as its STD clinic which houses the VCT program. The patient caseload at the Katatura Hospital STD/HIV Clinic is 40 patients per day with 25% to 37% (10 -15 patients) of the caseload being HIV patients. The caseload has increased due to the introduction of the highly effective anti-retroviral therapy (HAART) program. Prior to the availability of HAART, patients chose not to come to the hospital as they felt that the hospital had nothing to offer. Those coming for care at the STD/HIV Clinic receive information and general counseling and then obtain an appointment for testing. They are encouraged to bring a family member, friend, or spouse who will serve as their support person at the time of disclosure of the HIV test results.

Patients who have been hospitalized with opportunistic infections receive prophylactic treatment. Those who had not been previously tested are in need of counseling prior to HIV testing

occurring. However due to the workload of the nursing staff, it has been difficult to get pre-test counseling done.

Patient Flow in the Clinics

Many stops are needed for patients to complete their visits. This results in a cumbersome and expensive system (i.e. payment for services, registration for visits, medical visit, visit to pharmacy, HIV counseling and testing, return for HIV test results) that serves as a deterrent for many patients to receive HIV counseling and testing. Additional money is needed for taxi rides and hospital fees. If they are working, one has to get off work to attend the numbers of visits required to complete HIV counseling and testing and obtain test results. In the STD/HIV Clinic, shortcuts have been made to make services more user friendly and easier for the patient to navigate.

Staffing

There has been a brain drain with nurses leaving for better paying jobs in South Africa and other countries. For a ward of 40 patients, there are a total of 5 RNs for around the clock staffing. There is no time to do counseling. Patients often present to the hospital with opportunistic infections due to HIV, but HIV/AIDS testing is not done due to lack of nursing staff to do pre-test counseling. Due to many different languages utilized in Namibia, it is difficult to do general counseling. Auxiliary nurses were graduated up and sent to school to be registered nurses. However, after completion of this education, they leave for better paying jobs. Tertiary education in Namibia is not free and costs approximately \$5,000 US Dollars per year to go.

Training

HIV counseling training has been reduced from five days to three days due to the costs of the training and absence from the job site. The current curriculum is not enough; follow-up training is needed. There are ongoing discussions now regarding the rollout of training for HIV counselors.

Distance education is being discussed with the possibility of videoconferencing. However, ongoing training is difficult to organize throughout Namibia. Currently the HIV Clinical Society has a system for continuing education. This training is at an additional cost of N400 (US \$60) for certification. Materials for study are mailed out with a three day exam period being in place.

Discussion and plans to standardize training for all is currently in progress.

Plans for Decentralization of Services

There are plans to decentralize HAART services. However, there is the need to train staff in ARV management before decentralization can occur. Training has started in six regional hospitals in the last five months for doctors, nurses, and pharmacists with plans for roll-out.

Supervision of Counselors/Quality Assurance

There is an ARV Committee at each site. It has representatives from administration, pharmacy, nursing, community leadership, and PLWA. They oversee quality assurance at each site. The Technical Advisory Committee sets standards for the ARV program and ensures that policies are in place.

Family Planning, Patient Attitudes, and Communication

Family planning services are available at Katatura Hospital. Condoms are provided free at the clinic. Condoms that are socially marketed are less expensive. Other condoms are more expensive. People are making choices between buying food or buying condoms.

Condom use for a woman is viewed as the woman being sexual involvement with other men. If men use a condom, it is seen that they are unfaithful. Right now there is not the understanding that condoms can also be used for family planning.

When a girl begins her menstrual period, there is a big celebration announcing that she is now a woman. However, this also makes it known that she is available as a sexual partner thus increasing her risk for her first sexual encounter at an early age, and increasing her risk for HIV.

The most important job that a girl sees that she can have is to be a mother. This is same for the man. Even the family members of young unmarried girls want her to be a mother. There are couples who are HIV+ who still desire to have a child. Even when the man knows that he is going to die he desires to have a child to carry on his lineage; he will look to father a child. Women who are HIV+ and have never had a child are jealous that the other wife has a child, and are driven to become pregnant.

It is very difficult for women to talk about sex or to negotiate sex. They feel that it is “unwomanly” to bring this topic up. In Uganda there were call in radio shows that helped to open up communication between men and women regarding sex topics. The show was a call-in show wherein one could call in to discuss topics related to sex. This allowed one to be involved in conversations about sex while still remaining anonymous.

Lifeline/Childline-Namibia

Informant: Amanda Kruger – National Director

Lifeline/Childline Namibia is affiliated with Life Line Southern Africa, a member of Lifeline International, which has over 200 centers in 15 different countries. Lifeline International is affiliated with the International Federation of Telephone Emergency Services which is a worldwide body of organizations that operate telephone counseling services. Two of their stated objectives include promoting the establishment of centers to respond to appeals for help over the telephone and at drop-in centers staffed by trained voluntary workers, and referring persons in need of follow-up counseling to professional persons or agencies equipped to handle such cases. Lifeline/Childline has a track record in training and supervision of community members who provide counseling. They are also fully conversant with the New Start VCT protocols due to their involvement in New Start VCT delivery in Katatura and Rundu. The goal of Lifeline/Childline in working with USAID/Namibia is to develop and implement an integrated counseling program to ensure effective VCT and PMTCT plus

services.¹⁵ Their plans are to pilot a program in 13 regions in the first 14 months of their program. Five of these regions are under USAID and will have programs opening up in the next 7 to 8 months. Partners of Lifeline/Childline include Catholic AIDS Action, Catholic Health Services, Evangelical Lutheran Church in the Republic of Namibia AIDS Programme (ELCAP), MoHSS, Heath Communication Partnership (HCP); Margaret Sanger, and the University of Namibia. Lifeline/Childline is the only NGO that specializes in counseling.

Becoming a Counselor

Community individuals interested in becoming a lay counselor undergoes a screening process. They must have completed 8 to 10 grades of schooling to ensure their ability to understand the curriculum. However education is not the only selection criteria. One's personality and motivation are also critical factors that are evaluated. Anyone with addiction problems are not accepted for training. The cost of counselor training is US \$170 to \$999 (NB1200 to NB6000), > 1 month subsidy. It is felt that if the student will have a better appreciation of the program if they have to pay for it.

Curriculum

The curriculum of the Lifeline/Childline program is broken down into different stages. The first stage includes personal growth and spirituality and involves self introspection. Activities include making a pie chart that identifies percentages of time required by the varied roles in one's life; drawing timelines of one's life; and discussions regarding differences between spirituality and religion are held. These activities encourage participants to open up and share with other group members. After completion of this module, a selection process occurs. Before one can move onto the next module, they must have completed a self evaluation, peer evaluation of each person in their group and be evaluated by the facilitator of the group. There needs to be a correlation between all of the evaluations that have occurred. If there is discordance between one's self-evaluation and the evaluation of one's peers and facilitator, then this presents a danger sign that illustrates the need for further work on one's self. If significant issues arise, one is only able to progress to the next module if they are willing to work on themselves. If no effort is applied to do the self-work that is needed, then it is felt that the course will have no value for the individual. Work during the first module is done in small groups of no more than 6 people with a facilitator to guide each group.

The second stage includes basic counseling skills. During this stage of training, video cameras are used for self and peer evaluations. There is a lot of practical training during this stage with additional sessions arranged for those needing additional time to work on varied issues. The breakdown of facilitators to trainees at this stage is as follows:

- 1 facilitator for every 6 people
- 4 facilitators for 20 people
- 6 facilitators for 30 people

Stage three of the curriculum is Probation Training which occurs on a one to one basis.

Facilitators for Lifeline/Childline are employed trained individuals. The total time for completion of the program is minimally 100 hours; 60 hours for theoretical training and 40 hours for practicum training. Upon completion of the training, no jobs are promised. Hiring and interviewing

¹⁵ Implementing AIDS Prevention and Care (IMPACT) Project. Subagreement between Family Health International (FHI) and LifeLine/Childline Namibia Windhoek, Namibia. January 2003.

for the program remain gray areas. How one interviews raises issues with whether or not they are chosen. It is the desire to train individuals who speak the local language, however the person interviewing them may not speak their language; thus making the interview process less than favorable for the person being interviewed.

Those individuals who have been chosen for the training program must adhere to the principles of the program. Their personal conduct outside of the classroom must be in line with program principles. They are seen as role models, therefore, inappropriate behavior can endanger their place in the program and any job they may have with the program. Commitment is seen as a major value in this program. Those who are very committed will exhibit this during the volunteer time. Those lacking commitment will fall out of the program.

The vision of Lifeline/Childline is to be the entry point for certification in lay counseling. Following certification, it is hoped that programs could be developed that will lead to a diploma in counseling. Certification and a degree in counseling will allow employment and a career path. Different modules will be added to the basic curriculum. Certificates will be dated. Those who have already completed training will only need to update their skills with the additional units that will be developed. It is anticipated that the certificate program will be in place between 2004 and 2005. They would like to seek options such as distance education for completion of the additional modules.

Currently the Social Auxiliary Worker Board has the task of developing standards for the auxiliary worker. Presently there is a 2 year diploma that is required. There is the need to create a category in the professional registration system for lay counselors. The service of lay counselors would need to be controlled by standards. At this time minimum standards and quality have not been established.

There are lay counselors that have been trained under various programs such as Philips Namibia, however there is no selection criteria and no skills maintenance program. The challenge is knowing how to upgrade counselors in a maintenance program.

Lifeline has noted that while there is commitment, poorer volunteers cannot afford the time to volunteer. They need food and taxi fare as incentives for their volunteer time. In Windhoek, there is a more affluent cadre of volunteers. However, outside of Windhoek, young, unemployed individuals function as the main counselors.

Supervision

Lifeline/Childline sees supervision as a supportive role for the trainee. Clinical supervision is seen as authority in the workplace and feels that it would be detrimental if the supportive role to the trainee is combined with the authoritative role. As noted in their sub-agreement with Family Health International (FHI), counseling supervision will involve monthly group meetings as well as face to face meeting with individual counselors in the presence of the supervisor as appointed by the implementing partner.⁶ Thus the supervisory role of Lifeline/Childline is to be seen more as mentoring of the trainees rather than clinical supervision.

Community Mobilization and Outreach

Outreach is also a major part of the work done by Lifeline/Childline. Community members are recruited, trained, and supervised to become voluntary counselors. Outreach educational activities are determined by community requests and volunteer needs. Topics include improving reproductive health, reduction of gender based violence, prevention of teen pregnancy and HIV/STIs.⁷ Since

obtaining a mobile vehicle in November, 2002, counseling increased by 300% to 400% in a four month period of time.

Impressions/Assessment #1: Lifeline/Childline has a strong history in providing a standardized curriculum and training program in counseling.

Impression/Assessment# 2: Lack of job security with completion of the counseling program

Students accepted into the Lifeline/Childline counseling program are not guaranteed a job upon completion of the program. Prolonged time lapses between program completion and finally securing a job can jeopardize the training that has been obtained in the program. Also, administrative supervision will not be the role of Lifeline/Childline.

Recommendation:

In an effort to employ counselors that complete the program as well as ensure supervisory oversight, the following is recommended:

1. Joint interviews with the participating hospitals and Lifeline/Childline.
2. Have hospitals interview candidates for counseling positions as well as Lifeline/Childline. The hospital agrees to hire the individual contingent upon successful interview with Lifeline/Childline.
3. The training program offered by Lifeline/Childline could be a part of the orientation and probationary period for these individuals. Successful completion of the training and clinical programs would be requirements for ongoing employment.
4. Have the hospitals (or USAID/Namibia) pay for the training as an employment benefit. This may allow more individuals to be eligible for training who otherwise could not afford the tuition costs.

Impression/Assessment # 2: Administrative supervision of counseling staff will not be done by Lifeline/Childline

Lifeline/Childline will offer a mentoring relationship rather than administrative supervision.

Recommendation:

1. Have an administrative supervisory system in place in hospitals that will be using the counselors.
2. Encourage and assist in the establishment of professional counseling positions in MoHSS and Social Worker Auxiliary Board with proper licensing/accreditation standards.

Impression/Assessment # 3: System is needed for incorporating counselors trained in other programs.

There are a number of counselors available who have completed other programs. However, their training may not have encompassed all that would be covered with the Lifeline/Childline curriculum.

Recommendation:

1. Establish a mechanism wherein these counselors are able to “test out” of portions of the program in which there is demonstrated proficiency. This would also include testing out of clinical portions of the curriculum upon appropriate assessment and observation of clinical skills.

Overall Recommendations for All Hospitals and USAID/Namibia**#1. Pay Issues/Staff Retention**

While changes in staff scheduling and salary are outside of the purview of USAID, strong recommendations can be provided to the appropriate governing bodies to look at monies allocated to staffing. Issues that plague nursing staffing throughout Africa are highlighted in a number of articles from South Africa. The articles note the following:

- a. need to transfer the image of nursing into a stimulating career choice
- b. the government has reduced the budget for training; thus reducing the number of training colleges for nurses
- c. increased patient loads for nurses (one nurse to 18 patients; 500 outpatients per day with 14 to 15 nurses detailed to this area.); nurses feeling that they are unable to provide good care under these conditions
- d. long hours and poor pay; the long hours interrupt family time
- e. after six years of service there is very little salary increase, thus senior nurses are making the same amount of money as junior nurses working one to five years
- f. lack of treatment policies for diseases such as HIV
- g. poor treatment of nursing staff
- h. need to unfreeze posts quickly to allow replacement of nurses who have emigrated
- i. late payment of annual registration fees¹⁶
- j. Africa spends approximately \$4 bn annually on recruiting 100,000 skilled expatriates. (this equals about 40,000 per expatriate)^{17, 18, 19}

¹⁶ Amupadhi. T. Nurses, social workers struck off for not paying annual fees. Namibian. March 12, 2003. <http://www.namibian.com.na/2003/march/national/03BC3504C@.html>

¹⁷ Shevel, A. Hospitals offer incentives in a bid to keep their staff. Home Systems Trust. September 6, 2003. <http://new.hst.org.za/news/index.php/20030207>.

¹⁸ South Africa: Government wakes up to flight of health workers. IRINnews.org. <http://www.irinnews.org/report.asp?ReportID27765>.

¹⁹ Naidoo. N. South Africa is losing hundreds of nurses each year. Natal Witness, 24 May 2000. <http://www.queensu.ca/samp/migdocs/Nurses.htm>.

An abstract of an article dated December 6, 2002, it is stated :... "NAMIBIA is negotiating with other governments in southern Africa about recruiting foreign nurses to fill vacancies created by increasing HIV-AIDS deaths and the resignation of staff, a senior administrator in the Ministry said this week. Many nurses have resigned this year to take up better paying posts, mainly in the United Kingdom (UK), putting pressure on a health system already under strain. Dr Norbert Forster, Under Secretary in the Ministry of Health and Social Services, told The Namibian that in some hospitals up to 30 per cent of posts in the category of enrolled nurses were vacant "noted that Namibia was negotiating with other governments to recruit foreign nurses to fill vacancies created by increasing HIV/AIDS deaths and the resignation of staff.²⁰ As noted above, enormous amounts of money is being spent to bring in expatriates to fill vacant positions. Strategies to address the nursing shortage and pay inequities utilized by government and private industry in the United States and private hospitals in South Africa include additional pay for certifications in specialized areas; advance practice nursing (nurse midwives, nurse practitioners, and nurse anesthetists); shift differentials for evening, night, and weekend shifts; charge nurse duties; flexible scheduling; holiday pay; locality pay based on geographic location; hazard pay; relocation bonuses; recruitment bonuses; sign-on bonuses; and additional pay for hard to fill positions; payment of a 14th cheque to nurses; provide performance based pay awards.^{21, 22, 23, 24, 25, 26} Some recommendations that may be applied in Namibia include:

Recommendations:

1. Make recommendations to the Ministry of Health, the Public Service Commission, and other appropriate agencies to use the same money that it takes to bring in additional nurses to upgrade the salaries of the current work force. Some examples that are occurring in the United States include:

- a). establishment of a career ladder for nurses with increasing pay commiserate with increased education (certificates, degrees, specialization), longevity)
- b) modifications in the pay schedule that will allow there to be a percentage increase in base salary for all nurses when they work evening, night, or weekend shifts rather than just for Sunday duty or on public holidays. If everyone is rotating to either day/evening or day/night rotations and rotating weekend shift duty then all would share in the benefits provided by the additional pay.

²⁰ <http://www.lopez1.com/lopez/nursing.shortages.short.staffing/african.nurses.htm>

²¹ Halbrook. S. Fair-pay issue galvanizes RNs at SUNY Stony Brook. <http://www.thecommunicator.org/comoct2001/nursesoct.htm>.

²² Kossler, M. Shortage of nurses leading hospitals to policy changes. Getting creative: Wage models revised at Bayfront, St. Joe's, others. The Business Journal of Tampa Bay. November 19, 2001. <http://tampabay.bizjournals.com/tampabay/stories/2001/11/19/story1.tml?t=printable>.

²³ Saturday Differential. CC Title 38 for Nurses and Allied Health Employees. Clinical Center, DHHS/NIH. Human Resources. http://ohrm.cc.nih.gov/info_center/NursAH/sat.htm.

²⁴ Shift Differential Pay. State of Texas Human Resources. <http://www.hr.state.tx.us/Compensation/shiftifferential.html>.

²⁵ The Nurse Career. Nurses for a Healthier Tomorrow. http://www.nursesource.org/nursing_careers.html.

²⁶ Shevel. A. op.cit.

c) Allow for flexible scheduling in the pay schedule which would allow for nurses to work 8, 10, or 12 hours shifts. Another option is utilizing a weekend alternative program wherein nurses who work every weekend (Saturday and Sunday) are paid for 36 or 40 hours rather than just 24 hours. This can provide more permanent weekend staffing.

d) Consultation with the American Nurses Association in the United States or other countries that have nurses' unions who can assist in creative pay and scheduling programs to ensure better pay for nursing staff.

2. Pay the annual registration fee for all staff who have this requirement. This would provide supplemental pay for staff that is not exorbitant, but still provides staff incentives. It will also maintain staff in the workplace.

3. Assist the Ministry of Health and Social Services and Catholic Health Services in establishing a pay schedule and supervisory system that is consistent for all staff across the board regardless of who is the employer of the staff. Having varied pay schedules and ability to be detailed is disruptive for dealing with staffing needs and staffing morale.

#2. Lack of Hospital Wide Infection Control Program Utilizing Universal Precautions

In an article entitled "The Impact of HIV/AIDS on the Health Professions in Developing Countries", it states that there is an unprecedented absence from work of doctors and nurses due to sickness, mainly, it is though, HIV. Females are more likely to be absent due to caring for family members suffering from HIV/AIDS. Staff in health systems in sub-Saharan Africa who are not specifically assigned to AIDS care and prevention give little thought to AIDS risk within their standard practices...Minimal standards of infection control are observed, gloves are frequently not work for giving injections or taking blood samples and supplies of bleach and alcohol are not maintained."²⁷

While there were guidelines on PMTCT practices to be used in labor and delivery in two of the three hospitals, there was a lack of hospital wide infection control practices utilizing universal precautions. These precautions are critical to prevent HIV contamination for hospital staff. Use of ARVs for hospital staff should be the back up to a strong hospital wide infection control program.

Recommendations:

1. There must be commitment to provide the necessary supplies that will provide protection of the staff while they work with HIV positive patients. These things will include:
 - a. an active infection control program with 100% hospital staff participation
 - b. hospital wide in-service on infection control
 - a. an active infection control committee utilizing universal precautions
 - b. hospital wide infection control guidelines for universal precautions that are implemented throughout the hospital

²⁷ The HIV/AIDS Crisis: A Commonwealth Response. The Impact of HIV/AIDS on the Health Professions in Developing Countries. Commonwealth Medical Association. http://www.para55.org/hiv_aids_crisis/cma_paper.htm.

- c. proper equipment to ensure proper disposal of contaminated supplies, i.e. incinerators, appropriate trash bags to identify biohazardous waste in all high risk patient areas,
- d. ensuring that necessary equipment for staff protection is included on the essential supply list for Namibia. Some examples of supplies include but are not limited to the following:
 - i. biohazardous trash bags
 - ii. gloves (sterile and non-sterile)
 - iii. masks
 - iv. heparin locks
 - v. needles and syringes
 - vi. bleach and appropriate cleaning supplies
 - vii. rubber/plastic aprons
 - viii. disposable drapes or to use in high risk patient care areas i.e. high risk maternity care ward, labor and delivery, TB wards, casualty ward; theatre. If disposable drapes are not used, laundry from these areas should be separated from other laundry by use of special bags.
 - ix additional staff to handle laundry if disposable drapes are not used.

3. Inclusion of Universal Precautions in in-service and pre-service education programs

#3. Lack of adequate patient care areas to assure confidentiality and basic human dignity for HIV + patients and PLWA.

A lack of physical space was a pressing issue in St. Martin's Hospital and Onandjokwe Hospital. Overcrowding in the maternity units, the TB units, the casualty units and medical units made it impossible to maintain patient confidentiality or basic human dignity. Also the ability to maintain infection control practices is also greatly compromised. The need for oral medications for pain relief was also stated by staff from St. Martin's and St. Mary's Hospitals

Recommendation

1. Consideration by USAID/NAMIBIA to construct additional patient care areas that will provide the necessary physical space that will continue to ensure patient confidentiality, patient dignity, and infection control measures consistent with universal precautions.
2. Assist with policy that would allow use of oral medications for pain relief at home or hospital for patients dying from HIV/AIDS.

#3. Need for administrative supervision for counseling staff/Need for additional counseling staff.

Lifeline/Childline does not see their role as administrative supervisors for the candidates they train for counseling. It was felt by the staff at St. Martin's hospital that all physician and nursing staff should be able to do HIV/AIDS counseling.

Recommendation:

1. The establishment of supervisory lines for counseling staff is needed if not already in place. Joint recruitment and interviews by administrative supervisors at the hospitals and Lifeline/Childline staff could begin this relationship.
2. Have HIV/AIDS counseling by the responsibility of all physician and nursing staff and incorporated into their job description. In-service education would be needed to complete the necessary training needed to accomplish this.
3. Encourage and assist in the establishment of professional counseling positions in the MoHSS with proper licensing/accreditation standards.

#4. Community strategy should include call-in radio show and meetings with health committees.

Communication strategies that were cited by women, VCT counselors, and service delivery providers included having a call-in radio show wherein questions re: HIV/AIDS could be answered on the radio show and anonymous discussion of HIV/AIDS could be held. It was also strongly advised by these groups to contact the health committees in each community along with having a campaign to get men in for HIV/AIDS testing. Information is also needed regarding signs and symptoms of HIV/AIDS.

Recommendation:

1. Listen to the women and the providers by employing the strategies listed above.
2. Transportation is essential to access remote villages for communication messages regarding PMTCT, HAART, HIV/AIDS as well as for patient follow-up. The purchase of vehicles, motorcycles, and bicycles for use by outreach staff is highly recommended.

